MEDICAID

MONTANA MEDICAID PRIOR AUTHORIZATION REQUEST FORM
Hearing Aid Services (Rev., July 2003)

HEARING AID

Patient Name, Address, Telephone Number, Date of Birth Medicaid Number	**Hearing Aid Dispenser Name**, Address, Telephone Number Medicaid Provider Number
Referring Physician Name, Address, Telephone Number	**Audiologist Name**, Address, Telephone Number

1. Does the patient presently have hearing aid(s)? **Y / N**
   If yes, please complete the following:

Make_____, Model_____, Date Acquired_____

Replacement Remarks:

2. Does the patients conditions meet the criteria specified in the Montana Medicaid Hearing Aid Services Provider Manual? **Y / N**

3. Has the patient received a trial use of this item? **Y / N**
   If yes, for how long: _____

4. Does the patient have the ability to operate/use this requested item as intended by the items manufacture? **Y / N**

SPECIFICATION LIST

NOTE: ALL BILLABLE ITEMS/SERVICES THAT MAKE UP THIS REQUEST MUST BE LISTED INDIVIDUALLY BELOW. If additional space is needed, a continued sheet can be attached to this document as long as the pertinent patient and supplier information is included at the top of the attachment.

HCPCS	Description	Manufacture	Model/Product #	*Departmental Use Only*

I certify that the information contained in this document and its attachments/supporting documents are true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability. I further understand my responsibilities, as a condition of participation in the Montana Medicaid Program , to comply with all applicable state and federal statutes, rules, regulations and policies.

Dispenser Signature: _____ **DATE** _____/_____/_____ *(Stamps Are Not Acceptable)*

Attachments: This form must be accompanied by copies of supporting documentation to justify the medical need of the requested items. Supporting documentation includes, but is not limited the physicians referral for audiological evaluations, audiology report, audiogram and CMN.

MONTANA
Department of Public Health & Human Services